

TONY MURCZEK, N.D. L.Ac., A.T.C.
3449 NE 25TH AVENUE
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MOUNTAIN SPRING
HEALTH CLINICSM

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Age: _____ Date of Birth: _____ Gender: Female / Male

Marital Status:

- Married Widowed
 Separated Single
 Divorced Partnership

Live with:

- Spouse Parents Other:
 Partner Children _____
 Friends Alone _____

Occupation: _____ Hours per week: _____ Retired: _____

Employer: _____ Phone Number: _____

Address: _____

How did you hear about our clinic? _____

Has any other family member been a patient at this clinic? _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Address: _____

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HEALTH HISTORY

Are you currently receiving healthcare? Yes / No

If yes, where and from whom: _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

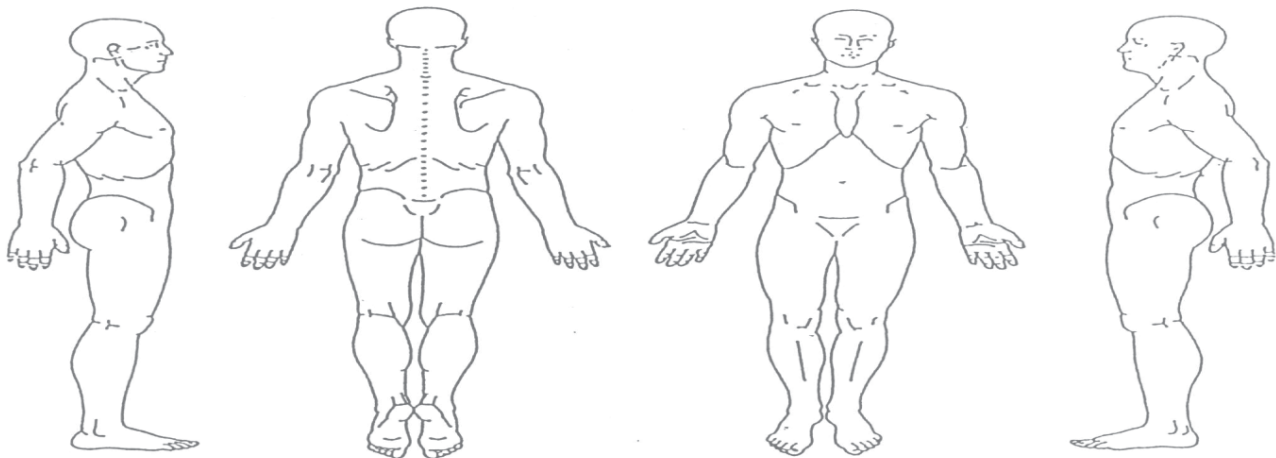
What are your most important health problems? List as many as you can in order of importance:

1) _____

2) _____

3) _____

Please mark painful or distressed areas below:



FAMILY MEDICAL HISTORY

Diabetes

Cancer

Stroke

Epilepsy

Arthritis

Tuberculosis

Heart Disease

High Cholesterol

High Blood Pressure

Mental Illness

Asthma/Hayfever/Hives

Other relevant family history? _____

Asthma

Allergies

Kidney Disease

Glaucoma

Anemia

PAST HEALTH HISTORY

(include dates)

Major Illnesses: _____

Major Surgeries: _____

Other Significant Trauma: _____

Check any of the following diseases you've had:

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | |
| <input type="checkbox"/> Sexually Transmitted | | <input type="checkbox"/> Other: _____ | |

CHILDHOOD ILLNESSES

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles | <input type="checkbox"/> German Measles |

HOSPITALIZATION, SURGERY, IMAGING

What hospitalizations, surgeries, X-rays, CAT Scans, EEG, EKGs have you had?

_____ Year: _____ Year: _____

_____ Year: _____ Year: _____

ALLERGIES

Are you hypersensitive or allergic to:

any drugs? _____

any foods? _____

any environmental or chemicals? _____

CURRENT HEALTH HISTORY

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

What medications do you currently take or use?

- | | | | | | |
|--------------------------|--|--------------------------|--|--------------------------|---|
| Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> Laxatives | <input type="checkbox"/> | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> | <input type="checkbox"/> Cortisone | <input type="checkbox"/> | <input type="checkbox"/> Appetite suppressants | <input type="checkbox"/> | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> Thyroid medications | <input type="checkbox"/> | <input type="checkbox"/> Sleeping pills |

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

- 1) _____ 2) _____
 3) _____ 4) _____
 5) _____ 6) _____

General

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.
 Maximum Weight: _____ When: _____
 When during the day is your energy the best? _____ worst? _____

Typical Food Intake

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____ Drinks: _____

What food or beverage do you consume the most of or absolutely cannot live without?

Habits

Y=a condition you have now N=never had P=significant problem in the past

Main interests and hobbies? _____

Do you exercise? Y / N If yes, what kind? _____ How often? _____

Do you have a religious or spiritual practice? Y / N If yes, what kind? _____

Average 6-8 hours sleep?	Y N P	Watch television?	Y N P
Sleep well?	Y N P	How many hours? _____	
Awaken rested?	Y N P	Read?	Y N P
Have a supportive relationship?	Y N P	How many hours? _____	
Have a history of abuse?	Y N P	Do you eat 3 meals a day?	Y N P
Any major traumas?	Y N P	Do you go on diets often?	Y N P
Use recreational drugs?	Y N P	Do you eat out often?	Y N P
Been treated for drug dependence?	Y N P	Do you drink coffee?	Y N P
Use alcoholic beverages?	Y N P	Drink black/green tea?	Y N P
Treated for alcoholism?	Y N P	Do you drink cola/other sodas?	Y N P
Do you use tobacco?	Y N P	Do you eat refined sugar?	Y N P
How many years? _____		Do you add salt?	Y N P
Packs per day? _____		What is your water intake? _____ /8oz glasses	
Enjoy your work?	Y N P	Source? _____	
Take vacations?	Y N P	(tap, filtered, reverse osmosis, distilled)	
Spend time outside?	Y N P		

REVIEW OF SYSTEMS

Mental/Emotional

Treated for Emotional Problems	Y	N	P
Mood Swings	Y	N	P
Considered/Attempted Suicide	Y	N	P
Poor Concentration	Y	N	P
Depression	Y	N	P
Anxiety or Nervousness	Y	N	P
Tension	Y	N	P
Memory Problems	Y	N	P

Immune

Reactions to Immunizations	Y	N	P
Chronic Fatigue Syndrome	Y	N	P
Chronically Swollen Glands	Y	N	P
Reactions to Vaccinations	Y	N	P
Chronic Infections	Y	N	P
Slow Wound Healing	Y	N	P

Endocrine

Hypothyroid	Y	N	P
Hypoglycemia	Y	N	P
Excessive Thirst	Y	N	P
Fatigue	Y	N	P
Heat or Cold Intolerance	Y	N	P
Diabetes	Y	N	P
Excessive Hunger	Y	N	P
Seasonal Depression	Y	N	P

Neurologic

Seizures	Y	N	P
Muscle Weakness	Y	N	P
Loss of Memory	Y	N	P
Vertigo or Dizziness	Y	N	P
Paralysis	Y	N	P
Numbness or Tingling	Y	N	P
Easily Stressed	Y	N	P
Loss of Balance	Y	N	P

Skin

Rashes	Y	N	P
Acne, Boils	Y	N	P
Color Change	Y	N	P
Lumps	Y	N	P
Eczema, Hives	Y	N	P
Itching	Y	N	P
Perpetual Hair Loss	Y	N	P
Night Sweats	Y	N	P

Head

Headaches	Y	N	P
Migraines	Y	N	P
Head Injury	Y	N	P
Jaw/TMJ Problems	Y	N	P

Eyes

Spots in Eyes	Y	N	P
Impaired Vision	Y	N	P
Blurriness	Y	N	P
Color Blindness	Y	N	P
Double Vision	Y	N	P
Cataracts	Y	N	P
Glasses or Contacts?	Y	N	P
Eye Pain/Strain	Y	N	P
Tearing or Dryness	Y	N	P
Glaucoma	Y	N	P

Ears

Impaired Hearing	Y	N	P
Earaches	Y	N	P
Ringing	Y	N	P
Dizziness	Y	N	P

Nose and Sinuses

Frequent Colds	Y	N	P
Stiffness	Y	N	P
Sinus Problems	Y	N	P
Nose Bleeds	Y	N	P
Hayfever	Y	N	P
Loss of Smell	Y	N	P

Mouth and Throat

Frequent Sore Throat	Y	N	P
Teeth Grinding	Y	N	P
Gum Problems	Y	N	P
Dental Cavities	Y	N	P
Copious Saliva	Y	N	P
Sore Tongue/Lips	Y	N	P
Hoarseness	Y	N	P
Jaw Clicks	Y	N	P

Neck

Lumps	Y	N	P
Goiter	Y	N	P
Swollen Glands	Y	N	P
Pain or Stiffness	Y	N	P

Respiratory

Cough	Y	N	P
Spitting-up Blood	Y	N	P
Asthma	Y	N	P
Pneumonia	Y	N	P
Emphysema	Y	N	P
Pain on Breathing	Y	N	P
Shortness of Breath at Night	Y	N	P
Tuberculosis	Y	N	P
Sputum	Y	N	P
Wheezing	Y	N	P
Bronchitis	Y	N	P
Pleurisy	Y	N	P
Difficulty Breathing	Y	N	P
Shortness of Breath	Y	N	P
Shortness of Breath Lying Down	Y	N	P

Cardiovascular

Heart Disease	Y	N	P
High/Low Blood Pressure	Y	N	P
Blood Clots	Y	N	P
Phlebitis	Y	N	P
Rheumatic Fever	Y	N	P
Swelling in Ankles	Y	N	P
Angina	Y	N	P
Murmurs	Y	N	P
Fainting	Y	N	P
Palpitations/Fluttering	Y	N	P
Chest Pain	Y	N	P

Gastrointestinal

Trouble Swallowing	Y	N	P
Change in Thirst	Y	N	P
Change in Appetite	Y	N	P
Nausea/Vomiting	Y	N	P
Ulcer	Y	N	P
Jaundice (yellow skin)	Y	N	P

Gastrointestinal (continued)

Gall Bladder Disease	Y	N	P
Liver Disease	Y	N	P
Hemorrhoids	Y	N	P
Heartburn	Y	N	P
Abdominal Pain or Cramps	Y	N	P
Belching or Passing Gas	Y	N	P
Constipation	Y	N	P
Diarrhea	Y	N	P
Bowel Movements: How often? _____			
Is this a change? _____			
Black Stools	Y	N	P
Blood in Stool	Y	N	P

Urinary

Pain on Urination	Y	N	P
Frequency at Night	Y	N	P
Frequent Infections	Y	N	P
Increased Frequency	Y	N	P
Inability to Hold Urine	Y	N	P
Kidney Stones	Y	N	P

Musculoskeletal

Joint Pain or Stiffness	Y	N	P
Broken Bones	Y	N	P
Muscle Spasms or Cramps	Y	N	P
Arthritis	Y	N	P
Weakness	Y	N	P
Sciatica	Y	N	P

Blood/Peripheral Vascular

Easy Bleeding or Bruising	Y	N	P
Deep Leg Pain	Y	N	P
Varicose Veins	Y	N	P
Anemia	Y	N	P
Cold Hands/Feet	Y	N	P
Thrombophlebitis	Y	N	P

FOR MEN

Date of last prostate check-up: _____

PSA results: _____ Manual prostate exam results: _____

Please indicate if you have experienced the following in the past 3 months:

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Dribbling |
| <input type="checkbox"/> Retention of Urine | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Impotence | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Testicular Pain | <input type="checkbox"/> Groin Pain |
| <input type="checkbox"/> Pain on Urinating | <input type="checkbox"/> Difficulty Starting Urination | | |

FOR WOMEN

Age of first period: _____ Age of last period (menopause): _____

Length of cycle (days): _____ Date of last period: _____

Are you pregnant? Yes / No / Maybe

Number of pregnancies: _____ Date of last gynecologic exam: _____

Number of live births: _____ Pap smear: Negative / Positive

Number of miscarriages: _____ Mammogram results: _____

Number of abortions: _____ Bone Density Scan results: _____

Have you been diagnosed with:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Other: _____ | | |

Are you on hormones? Yes / No If so, what? _____

Are you currently taking birth control pills? Yes / No If yes, for how long? _____

Are you having difficulty getting pregnant? Yes / No If so, for how long? _____

Please indicate if you have experienced the following in the past 3 months:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Swollen breasts | <input type="checkbox"/> Mood Swing | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Pain During Menses | <input type="checkbox"/> Pain After Menses | |
| <input type="checkbox"/> Pain Before Menses | <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Irregular Menses | |
| <input type="checkbox"/> Bleeding Between Cycles | <input type="checkbox"/> No Menses | <input type="checkbox"/> Bloating | |

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

- 1) Why did you choose to come to this clinic? _____

- 2) What do you know about our approach? _____

- 3) What three expectations do you have from this visit to our clinic?
 - a. _____
 - b. _____
 - c. _____
- 4) What long-term expectations do you have from working with our clinic? _____

- 5) What expectations do you have of me personally as your physician? _____

- 6) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? *(10 being 100% committed)*
0% 0 1 2 3 4 5 6 7 8 9 10 100%
- 7) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? _____
Self-destructive lifestyle habits? _____
- 8) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you? _____
- 9) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will making? _____
- 10) Are you willing to follow a treatment program designed to help you return to health for at least three months? Yes / No
- 11) Are you willing to take supplements? Yes / No
- 12) Are you willing to make dietary changes? Yes / No
- 13) Are you willing to start a moderate exercise program? Yes / No

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OFFICE POLICIES

- **Making Appointments:** Appointments are made directly with my staff or done by listening to my office hours and leaving two to three day and time possibilities. My staff or I will call you back with confirmation of your appointment day and time.
- **Cancellation Policy:** Missed appointments without prior notification is subject to a \$75.00 charge. Please give prior notice of at least 24 hours so other patients can be helped in that time slot.
- **Payment Policy:** We charge for services provided. Payment is due at the time of service. Cash, check, Visa or MasterCard are accepted. There will be a \$30.00 fee for all returned checks.
- **We do not bill** for medicinaries and typically insurance companies will not cover them under their policies. We do not accept returns on any projects. Please be sure before you buy. This policy is in effect for our safety.
- **Please refrain** from wearing any perfume, cologne, aftershave, hairspray, essential oils, makeup, etc. to respect others in the clinic that may be chemically sensitive.
- **Childcare Policy:** We do not offer childcare in this clinic. Please do not leave children unattended.
- **Please notify us** when your address and/or phone number changes as soon as possible.
- **Cell Phones:** Please turn off all cell phones before entering the treatment rooms.

OUR POLICY ON INSURANCE

You will be provided with a superbill with the appropriate information and codes for you to send to your medical insurance company. It is your responsibility to be aware of the medical services covered by your insurance policy. You will pay Mountain Spring Health Clinic, LLC at the time of service and get reimbursed directly from your insurance company.

Patient Signature: _____ Date: _____



Mountain Spring
HEALTH CLINIC

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent.

As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care.

It is important that you understand that your information can be used and shared in the following ways:

- ✓ For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- ✓ With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- ✓ To protect the public's health, such as reporting when the flu is in your area.
- ✓ To make required reports to the police, such as gunshot wounds.
- ✓ Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed.

Please check all that apply:

Please do not phone me at home. Use this alternate phone number: _____

Please do not phone me at work. Use this alternate phone number: _____

Please do not leave messages on my answering machine.

Please do not contact me by email.

Please send mail, including my bills, to this alternate address: _____

Other request (please describe): _____

Patient/Guardian Signature Date

Patient Name (Please Print. Include parent/guardian name if patient is a minor)